		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0001636

Facility Name: Champaign County Nursing Home

Address: 1701 East Main St. (Number) Urbana (City) 61802-2836 (Zip Code)

County: Champaign

Telephone Number: (217) 384-3784 **Fax #** (217) 337-0120

IDPA ID Number: 366006910001

Date of Initial License for Current Owners: 04/26/1905

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership	X	County		
IRS Exemption Code			Corporation		Other		
			"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (217) 753-3858
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/03 to 11/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	153	Skilled (SNF)	153	55,998	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,496	3
4		Intermediate/DD			4
5	34	Sheltered Care (SC)	34	12,444	5
6		ICF/DD 16 or Less			6
7	243	TOTALS	243	88,938	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	573	1,415	5,346	7,334	8
9	SNF/PED					9
10	ICF	23,189	39,359		62,548	10
11	ICF/DD					11
12	SC	1,766	1,578		3,344	12
13	DD 16 OR LESS					13
14	TOTALS	25,528	42,352	5,346	73,226	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.33%

D. How many bed-hold days during this year were paid by Public Aid?
9 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Adult Day Care; Child Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1943

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 153 and days of care provided 5,346

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/04 Fiscal Year: 11/30/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	817,131	62,510	22,425	902,066		902,066	(2,752)	899,314			1
2	Food Purchase		575,822		575,822		575,822	(21,782)	554,040			2
3	Housekeeping	428,665	29,560	120	458,345		458,345	(2,845)	455,500			3
4	Laundry	134,093	25,606		159,699		159,699		159,699			4
5	Heat and Other Utilities			368,235	368,235		368,235	(35,294)	332,941			5
6	Maintenance	76,434	16,190	89,780	182,404		182,404	(10,157)	172,247			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,456,323	709,688	480,560	2,646,571		2,646,571	(72,830)	2,573,741			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	3,455,272	275,612	211,627	3,942,511		3,942,511	(98)	3,942,413			10
10a	Therapy	58,990	1,175	292,902	353,067		353,067		353,067			10a
11	Activities	205,222	4,219		209,441		209,441		209,441			11
12	Social Services	118,149			118,149		118,149		118,149			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Day Care Expenses	351,127	2,021	107,795	460,943		460,943	(460,943)				15
16	**TOTAL Health Care and Programs**	4,188,760	283,027	616,524	5,088,311		5,088,311	(461,041)	4,627,270			16
	C. General Administration											
17	Administrative	110,356		55,487	165,843		165,843	(1,340)	164,503			17
18	Directors Fees											18
19	Professional Services			46,065	46,065		46,065	(1,119)	44,946			19
20	Dues, Fees, Subscriptions & Promotions			42,107	42,107		42,107	(2,979)	39,128			20
21	Clerical & General Office Expenses	362,297	18,574	70,667	451,538		451,538	(21,664)	429,874			21
22	Employee Benefits & Payroll Taxes			1,488,977	1,488,977		1,488,977	35,649	1,524,626			22
23	Inservice Training & Education			3,981	3,981		3,981		3,981			23
24	Travel and Seminar			11,469	11,469		11,469		11,469			24
25	Other Admin. Staff Transportation			1,289	1,289		1,289	(31)	1,258			25
26	Insurance-Prop.Liab.Malpractice			233,401	233,401		233,401	(6,214)	227,187			26
27	Other (specify):*											27
28	**TOTAL General Administration**	472,653	18,574	1,953,443	2,444,670		2,444,670	2,302	2,446,972			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,117,736	1,011,289	3,050,527	10,179,552		10,179,552	(531,569)	9,647,983			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Champaign County Nursing Home #0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			245,362	245,362		245,362	(29,968)	215,394			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,605	19,605		19,605		19,605			35
36	Other (specify):*											36
37	**TOTAL Ownership**			264,967	264,967		264,967	(29,968)	234,999			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	22,734	141,121		163,855		163,855		163,855			39
40	Barber and Beauty Shops	51,733	1,456		53,189		53,189	(50)	53,139			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			114,742	114,742		114,742		114,742			42
43	Other (specify):* Nonallowable Costs			67,412	67,412		67,412	(67,412)				43
44	**TOTAL Special Cost Centers**	74,467	142,577	182,154	399,198		399,198	(67,462)	331,736			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,192,203	1,153,866	3,497,648	10,843,717		10,843,717	(628,999)	10,214,718			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$ (460,943)	15	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,615)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,804)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(18,981)	21		28
29	Other-Attach Schedule (See page 5A)	(141,656)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (628,999)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (628,999)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Champaign County Nursing Home

ID# 0001636

Report Period Beginning: 12/01/03

Ending: 11/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-employee training	$ (90)	43	1
2	Public relations expense	(431)	43	2
3	Cable TV expense	(2,075)	43	3
4	General liability claims	(48,240)	43	4
5	Kiwanis dues	(175)	20	5
6	Offset revenue against beauty shop supplies	(50)	40	6
7	Child Day Care Benefits	116,111	22	7
8	Offset revenue against employee benefits	(248)	22	8
9	Offset revenue against clerical expense	(527)	21	9
10	Offset revenue against nursing supplies	(98)	10	10
11	Offset revenue against food cost	(2,809)	2	11
12				12
13				13
14	Dietary	(2,752)	1	14
15	Food	(18,656)	2	15
16	Housekeeping	(2,845)	3	16
17	Utilities	(35,294)	5	17
18	Maintenance	(10,157)	6	18
19	Administrative	(1,340)	17	19
20	Professional Fees	(1,119)	19	20
21	Office Expense	(2,156)	21	21
22	Employee Benefits	(80,531)	22	22
23	Staff Transportation	(31)	25	23
24	Insurance	(6,214)	26	24
25	Depreciation	(29,968)	30	25
26	Lab Fees	(11,961)	43	26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(141,656)		49

Champaign County Nursing Home
Provider #: 0001636
12/01/03 to 11/30/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(2,752)	0	0	0	0	0	0	0	0	0	0	(2,752)	1
2	Food Purchase	(21,465)	0	0	0	0	0	0	0	0	0	0	(21,465)	2
3	Housekeeping	(2,845)	0	0	0	0	0	0	0	0	0	0	(2,845)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(35,294)	0	0	0	0	0	0	0	0	0	0	(35,294)	5
6	Maintenance	(10,157)	0	0	0	0	0	0	0	0	0	0	(10,157)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(72,513)	0	0	0	0	0	0	0	0	0	0	(72,513)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(98)	0	0	0	0	0	0	0	0	0	0	(98)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(460,943)	0	0	0	0	0	0	0	0	0	0	(460,943)	15
16	**TOTAL Health Care and Programs**	(461,041)	0	0	0	0	0	0	0	0	0	0	(461,041)	16
	C. General Administration													
17	Administrative	(1,340)	0	0	0	0	0	0	0	0	0	0	(1,340)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,119)	0	0	0	0	0	0	0	0	0	0	(1,119)	19
20	Fees, Subscriptions & Promotions	(2,979)	0	0	0	0	0	0	0	0	0	0	(2,979)	20
21	Clerical & General Office Expenses	(21,664)	0	0	0	0	0	0	0	0	0	0	(21,664)	21
22	Employee Benefits & Payroll Taxes	35,332	0	0	0	0	0	0	0	0	0	0	35,332	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(31)	0	0	0	0	0	0	0	0	0	0	(31)	25
26	Insurance-Prop.Liab.Malpractice	(6,214)	0	0	0	0	0	0	0	0	0	0	(6,214)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	1,985	0	0	0	0	0	0	0	0	0	0	1,985	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(531,569)	0	0	0	0	0	0	0	0	0	0	(531,569)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Champaign County Nursing Home # 0001636 **Report Period Beginning:** 12/01/03 **Ending:** 11/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(29,968)	0	0	0	0	0	0	0	0	0	0	(29,968)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(29,968)	0	0	0	0	0	0	0	0	0	0	(29,968)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(50)	0	0	0	0	0	0	0	0	0	0	(50)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(67,412)	0	0	0	0	0	0	0	0	0	0	(67,412)	43
44	**TOTAL Special Cost Centers**	(67,462)	0	0	0	0	0	0	0	0	0	0	(67,462)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(628,999)	0	0	0	0	0	0	0	0	0	0	(628,999)	45

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Champaign County	100	N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Treasury services	$ 5,963	Champaign County	100.00%	$ 5,963	$	1
2	V	17	Auditor's Office services	49,524	Champaign County	100.00%	49,524		2
3	V	22	IMRF	297,590	Champaign County	100.00%	297,590		3
4	V	22	FICA	434,903	Champaign County	100.00%	434,903		4
5	V	22	Workers Compensation Ins.	152,870	Champaign County	100.00%	152,870		5
6	V	22	Unemployment Insurance	73,041	Champaign County	100.00%	73,041		6
7	V	22	Health Insurance	429,948	Champaign County	100.00%	429,948		7
8	V								8
9	V								9
10	V								10
11	V				Recorded on facility books and included on Schedule V, Column 3				11
12	V								12
13	V								13
14	Total			$ 1,443,839			$ 1,443,839	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	See attached list	Board of Directors	Administrative	0.00	None		<1%		None	N/A	2
3											3
4											4
5											5
6											6
7											7
8	Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business										8
9	transactions with the nursing home during the reporting period.										9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Champaign County
Street Address: 1776 East Washington
City / State / Zip Code: Urbana, IL 61802
Phone Number: (217) 384-3776
Fax Number: (217) 337-0120

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Treasury services	Direct Costs	1	All Co. Depts.	$ 5,963	$	1	$ 5,963	1
2	17	Auditor's Office services	Direct Costs	1	All Co. Depts.	49,524		1	49,524	2
3	22	IMRF	Direct Costs	1	All Co. Depts.	297,590		1	297,590	3
4	22	FICA	Direct Costs	1	All Co. Depts.	434,903		1	434,903	4
5	22	Workers Compensation Ins.	Direct Costs	1	All Co. Depts.	152,870		1	152,870	5
6	22	Unemployment Insurance	Direct Costs	1	All Co. Depts.	73,041		1	73,041	6
7	22	Health Insurance	Direct Costs	1	All Co. Depts.	429,948		1	429,948	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15				Recorded on facility books and included on Schedule V, Column 3						15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,443,839	$		$ 1,443,839	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Champaign County Day Care
Street Address: 1701 East Main St.
City / State / Zip Code: Urbana, IL 61802
Phone Number: (217) 384-3784
Fax Number: (217) 337-0120

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals	227,163		$ 84,935	$	7,360	$ 2,752	1
2	2	Food	Meals	227,165		575,822		7,360	18,656	2
3	3	Housekeeping	Square feet	63,455		29,680		6,082	2,845	3
4	5	Utilities	Square feet	63,455		368,235		6,082	35,294	4
5	6	Maintenance	Square feet	63,455		105,970		6,082	10,157	5
6	17	Administrative	Revenue	8,854,912		55,487		213,906	1,340	6
7	19	Professional Fees	Revenue	8,854,912		46,342		213,906	1,119	7
8	21	Office Expense	Revenue	8,854,912		89,241		213,906	2,156	8
9	22	Employee Benefits	Salaries	6,192,203		1,488,977		334,902	80,531	9
10	25	Staff Transportation	Revenue	8,854,912		1,289		213,906	31	10
11	26	Insurance - Auto	Direct	1		590		1	590	11
12	26	Insurance - Other	Revenue	8,854,912		232,811		213,906	5,624	12
13	30	Depreciation - Auto	Direct	1		7,135		1	7,135	13
14	30	Depreciation - Other	Square feet	63,455		238,227		6,082	22,833	14
15										15
16										16
17										17
18		Day care costs eliminated on Schedule V, Column 7.								18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,324,741	$		$ 191,063	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2				This Page Not Applicable								2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** None **Line #** N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999		8
	2000		9
	2001		10
	2002		11
	2003	N/A	12

County Facility: Does not pay real estate tax.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Champaign County Nursing Hom COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0001636

CONTACT PERSON REGARDING THIS REPORT Amanda Knight, Comptroller

TELEPHONE (217) 384-3784 FAX #: (217) 337-0120

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility does not pay real estate taxes.		$ N/A	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? N/A YES N/A NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 101,931 B. General Construction Type: Exterior Brick Frame Reinforced Concrete Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	1,859,520	1865	$ 2,100	1
2					2
3	TOTALS	1,859,520		$ 2,100	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	153		1975	1973	$ 2,085,435	$ 52,136	40	$ 52,136	$	$ 1,629,247	4
5	56		1910	1971	734,760		25			734,760	5
6	34			1971	207,240		25			207,240	6
7			1989	1989	34,891	872	40	872		13,524	7
8											8
	Improvement Type**										
9	Building improvements			1972	10,300		25			10,300	9
10	Building improvements			1973	146,645		25			146,645	10
11	Building improvements			1974	288,473		25			288,473	11
12	Building improvements			1974	18,482	462	40	462		14,030	12
13	Building improvements			1975	25,353		25			25,353	13
14	Building improvements			1976	6,342		15			6,342	14
15	Building improvements			1977	3,399		15			3,399	15
16	Building improvements			1977	8,548		25			8,548	16
17	Building improvements			1980	2,469		15			2,469	17
18	Building improvements			1981	36,818		15			36,818	18
19	Building improvements			1982	57,322		15			57,322	19
20	Building improvements			1983	31,084		10			31,084	20
21	Building improvements			1984	223,985	9,344	24	9,344		191,556	21
22	Building improvements			1985	57,958	2,953	20	2,953		56,126	22
23	Building improvements			1986	254,092	10,164	25	10,164		188,029	23
24	Building improvements			1987	81,739	4,153	20	4,153		72,686	24
25	Building improvements			1988	345,563	13,823	25	13,823		228,073	25
26	Building improvements			1989	64,947	2,598	25	2,598		40,268	26
27	Building improvements			1990	251,292	10,052	25	10,052		145,750	27
28	Building improvements			1991	163,384	6,535	25	6,535		88,226	28
29	Building improvements			1992	138,101	5,524	25	5,524		69,051	29
30	Building improvements			1993	62,716	2,509	25	2,509		28,850	30
31	Building improvements			1994	360,106	14,404	25	14,404		151,244	31
32	Building improvements			1995	28,420	1,138	25	1,138		10,808	32
33	Building improvements			1996	21,058	842	15	842		7,159	33
34	Parking lot			1977	25,035		15			25,035	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Tree care	1981	$ 465	$	15	$	$	$ 465	37
38	Landscaping additions	1982	1,870		10			1,870	38
39	Landscaping additions	1983	5,250		5			5,250	39
40	Landscaping additions	1987	3,491		5			3,491	40
41	Landscaping additions	1988	1,971		15			1,971	41
42	Landscaping additions	1989	6,125	220	15	220		6,125	42
43	Landscaping additions	1990	3,596	240	15	240		3,477	43
44	Landscaping additions	1991	11,069	738	15	738		9,968	44
45	Landscaping additions	1992	2,969	198	15	198		2,475	45
46	Parking lot expansion	1996	67,139	4,602	15	4,602		39,427	46
47	Smoke detectors	1997	4,524		5			4,524	47
48	Redecorating-ADC	1997	1,459		5			1,459	48
49	Sprinkler backflow preventor	1997	6,230	623	10	623		4,673	49
50	Fire door - Activity office	1997	626	63	10	63		471	50
51	Wall-Dietary	1997	705	70	10	70		527	51
52	Mini blinds - Dining area	1997	1,045		5			1,045	52
53	Tuckpointing - Administration bldg	1997	11,400	456	25	456		3,420	53
54	Flooring improvements	1997	3,306		5			3,306	54
55	Asbestos removal	1998	45,350	1,814	25	1,814		11,781	55
56	Project planning - ARD expansion	1998	35,513		5			35,513	56
57	Air conditioning - Chiller replacement	1998	193,611	9,272	20	9,272		60,701	57
58	Hot water treatment system	1998	1,422		5			1,422	58
59	Pipe insulation	1998	3,201	160	20	160		1,040	59
60	Door sensor beam	1998	567		5			567	60
61	Vanity replacement (wing)	1998	16,236	812	20	812		5,277	61
62	Shower tile replacement (B wing)	1998	1,064	71	15	71		461	62
63	Heat exchanger replacement	1998	4,417	442	10	442		2,872	63
64	Pipe insulation	1998	97	5	20	5		32	64
65	Asbestos removal	1998	4,792	192	25	192		1,247	65
66	Cable for computer	1999	7,350	490	15	490		2,695	66
67	Chiller replacement electrical	1999	3,465	173	20	173		952	67
68	Door alarm on B wing	1999	1,808	181	10	181		995	68
69	Carpet - 3 offices	1999	814	81	5	81		814	69
70	TOTAL (lines 4 thru 69)		$ 6,228,904	$ 158,412		$ 158,412	$	$ 4,738,728	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,228,904	$ 158,412		$ 158,412	$	$ 4,738,728	1
2	Door alarm hook-up	1999	50	5	10	5		28	2
3	Stainless steel wall coverings	1999	1,382	69	20	69		380	3
4	Flipper cabinet w/ hanging tracks	1999	297	20	15	20		110	4
5	Flipper cabinet w/ hanging tracks	1999	1,216	81	15	81		446	5
6	Door magnets (door alarms)	1999	144	14	10	14		78	6
7	Ceramic flooring	1999	3,192	160	20	160		879	7
8	Carpet in 2 offices	1999	918	91	5	91		918	8
9	Hollow metal door	1999	788	39	20	39		215	9
10	Annunciator	1999	400	40	10	40		220	10
11	Unit heater for bus ban	1999	569	38	15	38		209	11
12	Privacy panels & hardware	1999	518	51	5	51		518	12
13	A-wing nursing station	1999	4,333	252	15	252		1,552	13
14	Hook-up call system	1999	734	49	15	49		269	14
15	Computer cable	2000	810	54	15	54		257	15
16	Stainless folding for shower rooms	2000	578	58	15	58		275	16
17	Vinyl flooring	2000	960	192	10	192		784	17
18	Concrete fountain	2000	1,000	40	25	40		180	18
19	Remodel Annex corner	2001	443	87	5	87		283	19
20	Conversion of Activity room to Dining	2001	2,079	416	5	416		1,352	20
21	Major repair-Walk-in refrigerator	2001	526	105	5	105		324	21
22	Vinyl flooring	2001	898	180	5	180		547	22
23	Stairway treads	2001	1,495	299	5	299		909	23
24	Carpet - Canopy walkway	2001	980	196	5	196		604	24
25	Tree removal	2001	975	98	10	98		350	25
26	Fire alarm update	2001	1,273	127	10	127		487	26
27	Dishwasher fan	2001	4,285	429	10	429		1,573	27
28	ADC alarm	2001	566	57	10	57		209	28
29	Activity room phone system	2001	110	11	10	11		37	29
30	Wing door alarm	2001	886	89	10	89		311	30
31	Door alarm system	2001	857	86	10	86		294	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,262,166	$ 161,845		$ 161,845	$	$ 4,753,326	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,262,166	$ 161,845		$ 161,845	$	$ 4,753,326	1
2	Hollow doors (3)	2002	635	32	20	32		93	2
3	Hollow door (1)	2002	514	26	20	26		71	3
4	Smoke detectors in ductwork	2002	23,325	2,333	10	2,333		6,480	4
5	Ductwork repair per Life Safety survey	2002	20,469	2,047	10	2,047		5,628	5
6	Smoke detectors in ductwork	2002	15,829	1,583	10	1,583		4,024	6
7	Air conditioner condensing unit	2002	971	65	15	65		152	7
8	Garage Door Repairs	2002	565	38	15	38		86	8
9	Removal of trees	2002	1,800	180	10	180		380	9
10	Sprinkler System Repair	2003	1,569	63	25	63		126	10
11	Compressor - Air Conditioner	2003	27,800	1,853	15	1,853		2,780	11
12	Heat Exchanger Repair	2003	5,559	370	15	370		401	12
13									13
14	Compressor - Walk in Cooler	2004	575	160	3	160		160	14
15	11 Sentry Door Alarms	2004	851	64	10	64		64	15
16	Security Lights	2004	6,526	435	40	435		435	16
17	Roof Repair	2004	2,600	130	10	130		130	17
18	Heating System Upgrade/Repair	2004	8,908	297	15	297		297	18
19	Door Alarms	2004	732	24	10	24		24	19
20	Land Improvements - Water Line Repair	2004	2,845	28	25	28		28	20
21									21
22									22
23									23
24									24
25									25
26									26
27	Less: Allocated to Day Care			(29,968)		(29,968)			27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,384,239	$ 141,605		$ 141,605	$	$ 4,774,685	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,539,206	$ 62,663	$ 62,663	$	3-15	$ 1,351,032	71
72	Current Year Purchases	42,952	3,855	3,855		3-15	3,855	72
73	Fully Depreciated Assets	391,350					391,350	73
74								74
75	TOTALS	$ 1,973,508	$ 66,518	$ 66,518	$		$ 1,746,237	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Use	96 Ford Bus	1996	$ 36,532	$ 3,653	$ 3,653	$	10	$ 31,054	76
77	Resident Use	98 Dodge Van	1998	33,746	3,375	3,375		10	21,935	77
78	Resident Use	Lift for Van	2001	537	107	107		5	358	78
79	Resident Use	97 Ford	2002	1,358	136	136		10	305	79
80	TOTALS			$ 72,173	$ 7,271	$ 7,271	$		$ 53,652	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,432,020	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 215,394	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 215,394	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,574,574	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Design & legal fees for	$ 243,388	92
93	new facility		93
94			94
95		$ 243,388	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 19,605 Description: Trash compactor - 3216, Mattress - 15460, Wound vac - 254, Compressor - 613, Other nursing - 62
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A (1,2,3)	1866 hrs	$ 22,665	1,781	$ 101,189	$ 320	3,647	$ 124,174	1
2	Licensed Speech and Language Development Therapist	10A (3)	hrs		719	42,320		719	42,320	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A (1,2,3)	3180 hrs	36,325	2,175	124,537	855	5,355	161,717	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 (2)	# of prescrpts				135,933		135,933	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 (1,2)	1081	22,734			5,188	1,081	27,922	12
13	Other (specify):									13
14	TOTAL			$ 81,724	4,675	$ 268,046	$ 142,296	10,802	$ 492,066	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,012,233	$ 1,012,233	1
2	Cash-Patient Deposits	13,898	13,898	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,770)	807,378	807,378	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	26,021	26,021	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	57,175	57,175	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,916,705	$ 1,916,705	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,100	2,100	13
14	Buildings, at Historical Cost	6,248,638	6,248,638	14
15	Leasehold Improvements, at Historical Cost	135,601	135,601	15
16	Equipment, at Historical Cost	2,045,681	2,045,681	16
17	Accumulated Depreciation (book methods)	(6,574,574)	(6,574,574)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Const. in Progress	243,388	243,388	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,100,834	$ 2,100,834	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,017,539	$ 4,017,539	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 112,238	$ 112,238	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,898	13,898	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	454,296	454,296	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due From Other Funds	195,510	195,510	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 775,942	$ 775,942	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 775,942	$ 775,942	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,241,597	$ 3,241,597	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,017,539	$ 4,017,539	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,999,857	1
2	Restatements (describe):		2
3	**Adjustment subsequent to prior report preparation**	(83)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,999,774	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(758,177)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (758,177)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,241,597	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,854,912	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,854,912	3
	B. Ancillary Revenue		
4	Day Care	181,971	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 181,971	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	133,284	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	49,607	13
14	Non-Patient Meals	2,910	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	91,242	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 277,043	23
	D. Non-Operating Revenue		
24	Contributions	19,587	24
25	Interest and Other Investment Income***	14,756	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 34,343	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See attached	737,271	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 737,271	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,085,540	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,646,571	31
32	Health Care	5,088,311	32
33	General Administration	2,444,670	33
	B. Capital Expense		
34	Ownership	264,967	34
	C. Ancillary Expense		
35	Special Cost Centers	284,456	35
36	Provider Participation Fee	114,742	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,843,717	40
41	**Income before Income Taxes (line 30 minus line 40)****	(758,177)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (758,177)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility files as part of County return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Champaign County Nursing Home
Provider #: 0001636
12/01/03 to 11/30/04 **Schedule 19A**

XVII. Income Statement
Line 28 Other Income(specify):

Description	Amount
Taxes - Current Operating	707,307
Other Operating Taxes	782
Mobile Home Tax	1,186
Payment in Lieu of Taxes	440
Cunningham Township	155
Resident Transportation	6,900
Late charges	6,178
Interfund Transfer from General Fund	10,000
Employee Reimbursement	3,732
Other Miscellaneous Revenue	591
Total - Line 28	737,271

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,096	2,164	$ 66,442	$ 30.70	1
2	Assistant Director of Nursing	2,094	2,094	54,683	26.11	2
3	Registered Nurses	20,000	20,150	421,644	20.93	3
4	Licensed Practical Nurses	28,284	28,400	479,864	16.90	4
5	Nurse Aides & Orderlies	158,148	159,170	1,926,772	12.11	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,836	5,046	58,990	11.69	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,096	2,285	46,781	20.47	9
10	Activity Assistants	15,705	15,705	158,441	10.09	10
11	Social Service Workers	6,529	6,768	118,149	17.46	11
12	Dietician					12
13	Food Service Supervisor	2,076	2,237	53,884	24.09	13
14	Head Cook	5,001	5,096	91,001	17.86	14
15	Cook Helpers/Assistants	74,979	76,152	672,246	8.83	15
16	Dishwashers					16
17	Maintenance Workers	6,297	6,297	76,434	12.14	17
18	Housekeepers	40,771	41,109	428,665	10.43	18
19	Laundry	13,834	13,862	134,093	9.67	19
20	Administrator	2,096	2,233	93,980	42.09	20
21	Assistant Administrator	487	532	16,376	30.78	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,116	22,472	362,297	16.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,110	2,110	21,438	10.16	31
32	Other Health Ca See attached	52,251	53,444	858,290	16.06	32
33	Other(specify) Beauty Shop	4,843	4,886	51,733	10.59	33
34	TOTAL (lines 1 - 33)	466,649	472,212	$ 6,192,203 *	$ 13.11	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	566	$ 22,425	1(3)	35
36	Medical Director	Monthly	4,200	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,600	10(3)	39
40	Physical Therapy Consultant	386	11,760	10A(3)	40
41	Occupational Therapy Consultant	366	10,401	10A(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	47	2,695	10A(3)	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,365	$ 55,081		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,123	$ 49,501	10(3)	50
51	Licensed Practical Nurses	3,986	133,614	10(3)	51
52	Nurse Aides	1,089	24,603	10(3)	52
53	TOTAL (lines 50 - 52)	6,198	$ 207,718		53

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home
Provider #: 0001636
12/01/03 to 11/30/04 **Schedule 20A**

XVIII. Staffing & Salary Costs
Line 32 Other Health Care (specify):

Description	Hours Worked	Hours Paid	Total Wages	Ave Hrly Wage
Care Plan Coordinators	4,378	4,600	90,707	19.72
Other Nursing Supervisors	15,321	15,788	342,350	21.68
Dental Hygienist	1,575	1,591	35,477	22.30
Adult Day Care	16,715	17,052	218,897	12.84
Child Day Care	10,351	10,502	132,230	12.59
Unit Secretary	3,911	3,911	38,629	9.88
Total - Line 32	52,251	53,444	858,290	16.06

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeremy Maupin	Administrator	0	$ 93,980
Nancy Richardson	Asst. Administrator	0	16,376
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 110,356

B. Administrative - Other

Description	Amount
Champaign County - Treasury Services	$ 5,963
Champaign County - Audit & Accounting Services	49,524
TOTAL (agree to Schedule V, line 17, col. 3)	$ 55,487
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heyl, Royster, Voelker, & Allen	Legal	$ 2,383
Lisa Salkovitz Kohn	Arbitrator	450
Fed Mediation & Conciliation Svc	Arbitrator	75
Altschuler, Melvoin and Glasser	Accounting	7,052
American Express Tax & Bus Svc.	Accounting	15,155
Medline Industries, Inc.	Medicare billing service	750
Champaign County Auditor	Accounting	2,305
Safeworks of Illinois	Employment consultant	1,175
Thomas, Maner & Haughey	Employment consultant	735
Employers' Assn. of Illinois	Employment consultant	2,000
Egix	Internet service	224
From page 21A		13,761
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 46,065

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 152,870
Unemployment Compensation Insurance	73,041
FICA Taxes	434,586
Employee Health Insurance	429,948
Employee Meals	317
Illinois Municipal Retirement Fund (IMRF)*	297,590
Employee Morale	14,670
Employee Physicals & Labs	5,493
Child Day Care benefit	116,111
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,524,626

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,430
Advertising: Employee Recruitment	18,643
Health Care Worker Background Check	
(Indicate # of checks performed 85)	705
Miscellaneous Dues	862
Illinois Health Care Association dues	12,276
Miscellaneous Subscriptions	1,327
Other Advertising	2,804
County Nursing Home Assoc of IL	2,060
Less: Public Relations Expense	(175)
Non-allowable advertising	(2,804)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,128

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached schedule	11,469
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,469

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Champaign County Nursing Home
Provider #: 0001636
12/01/03 to 11/30/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Brought forward from page 21		32,304
Vendor	Type	
Capital One FBS	Internet services	287
Champaign County Auditor	Internet connection	1,510
Ivans	Software support	1,794
Senior Living Systems	Software Support	6,570
Pinnacle Consulting	Operations Consultant	3,600
Total agreeing to Schedule V, Line 19, Col 3		46,065
Allocated to Day Care and eliminated		(1,119)
Total (agree to Schedule V, line 19, column 8)		44,946

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Champaign County Nursing Home # 0001636 Report Period Beginning: 12/01/03 Ending: 11/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA-12,276; County NH Assn. of IL-2,060**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **9 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **72,100** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **114,742**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **Yes - See page 8A** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **317** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Bray, Drake, Guthrie & Richardson** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	817,131	62,510	22,425	902,066	0	902,066	-2,752	899,314
2. Food Purchase	0	575,822	0	575,822	0	575,822	-21,782	554,040
3. Housekeeping	428,665	29,560	120	458,345	0	458,345	-2,845	455,500
4. Laundry	134,093	25,606	0	159,699	0	159,699	0	159,699
5. Heat and Other Utilities	0	0	368,235	368,235	0	368,235	-35,294	332,941
6. Maintenance	76,434	16,190	89,780	182,404	0	182,404	-10,157	172,247
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,456,323	709,688	480,560	2,646,571	0	2,646,571	-72,830	2,573,741
9. Medical Director	0	0	4,200	4,200	0	4,200	0	4,200
10. Nursing & Medical Records	3,455,272	275,612	211,627	3,942,511	0	3,942,511	-98	3,942,413
10a. Therapy	58,990	1,175	292,902	353,067	0	353,067	0	353,067
11. Activities	205,222	4,219	0	209,441	0	209,441	0	209,441
12. Social Services	118,149	0	0	118,149	0	118,149	0	118,149
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	351,127	2,021	107,795	460,943	0	460,943	-460,943	0
16. Total Health Care & Programs	4,188,760	283,027	616,524	5,088,311	0	5,088,311	-461,041	4,627,270
17. Administrative	110,356	0	55,487	165,843	0	165,843	-1,340	164,503
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	46,065	46,065	0	46,065	-1,119	44,946
20. Fees, Subscriptions & Promotion	0	0	42,107	42,107	0	42,107	-2,979	39,128
21. Clerical & General Office	362,297	18,574	70,667	451,538	0	451,538	-21,664	429,874
22. Employee Benefits & Payroll	0	0	1,488,977	1,488,977	0	1,488,977	35,649	1,524,626
23. Inservice Training & Education	0	0	3,981	3,981	0	3,981	0	3,981
24. Travel and Seminar	0	0	11,469	11,469	0	11,469	0	11,469
25. Other Admin. Staff Trans	0	0	1,289	1,289	0	1,289	-31	1,258
26. Insurance-Prop.Liab.Malpractice	0	0	233,401	233,401	0	233,401	-6,214	227,187
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	472,653	18,574	1,953,443	2,444,670	0	2,444,670	2,302	2,446,972
29. Total General Administrative	6,117,736	1,011,289	3,050,527	10,179,552	0	10,179,552	-531,569	9,647,983
30. Depreciation	0	0	245,362	245,362	0	245,362	-29,968	215,394
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	19,605	19,605	0	19,605	0	19,605
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	264,967	264,967	0	264,967	-29,968	234,999
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	22,734	141,121	0	163,855	0	163,855	0	163,855
40. Barber and Beauty Shop	51,733	1,456	0	53,189	0	53,189	-50	53,139
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	114,742	114,742	0	114,742	0	114,742
43. Other (specify):*	0	0	67,412	67,412	0	67,412	-67,412	0
44. Total Special Cost Ce	74,467	142,577	182,154	399,198	0	399,198	-67,462	331,736
45. Grand Total	6,192,203	1,153,866	3,497,648	10,843,717	0	10,843,717	-628,999	10,214,718

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,012,233	1,012,233
2. Cash - Patient Deposits	13,898	13,898
3. Accounts & Notes Recievable	807,378	807,378
4. Supply Inventory	0	0
5. Short-Term Investments	26,021	26,021
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	57,175	57,175
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	1,916,705	1,916,705
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	0
14. Buildings, at Historical Cost	6,248,638	6,248,638
15. Leasehold Improvements, Historical Cost	135,601	135,601
16. Equipment, at Historical Cost	2,047,781	2,047,781
17. Accumulated Depreciation (book methods)	-6,574,574	-6,574,574
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	243,388	243,388
23. other (specify):	0	0
24. Total Long-Term Assets	2,100,834	2,100,834
25. Total Assets	4,017,539	4,017,539
CURRENT LIABILITIES		
26. Accounts Payable	112,238	112,238
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	13,898	13,898
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	454,296	454,296
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	195,510	195,510
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	775,942	775,942
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	775,942	775,942
47.Total Equity	3,241,597	3,241,597
48.Total Liabilities and Equity	4,017,539	4,017,539

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	8,854,912
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	8,854,912
4. Day Care	181,971
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	181,971
9. Payments for Education	0
10. Other Governmental Grants	133,284
11. Nurses Aide Training Reimbursements	-
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	49,607
14. Non-Patient Meals	2,910
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	91,242
22. Laundry	0
Subtotal - Other Operating Revenue	277,043
24. Contributions	19,587
25. Interest and Other Investments Income	14,756
Subtotal - Non-Operating Revenue	34,343
27. Other Revenue (specify):	727,271
28. Other Revenue (specify):	10,000
Subtotal - Other Revenue	737,271
30. Total Revenue	10,085,540
31. General Services	2,646,571
32. Health Care	5,100,272
33. General Administration	2,444,670
34. Ownership	264,967
35. Special Cost Centers	272,495
35. Provider Participation Fee	114,742
37. Other	0
40. Total Expenses	10,843,717
41. Income Before Income Taxes	-758,177
42. Income Taxes	0
43. Net Income or Loss for the Year	-758,177

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